LANGE remarked that there was no question of the existence of the tumor at the time, and the only plausible explanation of the condition was that of a sudden obstruction of the main vessel. Dr. SANDS could not otherwise explain the occurrence. A similar occurence happened about twelve years previously in a man who had a well-marked pulsating aneurism of the left axillary artery and who complained of a sudden pain in his left arm, whereupon it was found that no pulsation could be felt in either the radial or the ulnar artery of that side, on account, it was supposed, of a large clot having been displaced from the sac and lodged in the upper part of the brachial artery. The aneurism ceased to pulsate and at the end of six weeks was entirely cured.—*N. Y. Surg. Society*, Nov. 8, 1886.

HEAD AND NECK.

I. Exsection of Temporo-Maxillary Joints for True Ankylosis. By A. G. GERSTER, M. D. (New York). In a semi-idiotic girl æt. 15, suffering from ankylosis of the jaw of some years standing, consequent upon a long-continued feverish illness with an abscess connected with one cheek, sufficient data for the diagnosis of true ankylosis, were not available, and it was decided to cut the upper insertion of the left masseter and eventually proceed to exsection of the left joint, where the origin of the disease was suspected to have been located, on account of atrophy of that side of the face, atrophy as a sequel of inflammation being a plausible supposition. An incision along the lower edge of the zygoma permitted a division of the muscle, which was not followed by any improvement of the functional defect. Therefore a vertical incision was added to the posterior end of the first incision, a triangular flap being thus raised, and the joint was exposed with some difficulty. This was due to the atrophy and smallness of the head of the inferior maxilla, which was found together with the glenoid cavity, bare of cartilage. The head was removed with the chisel, without any trouble or mishap, but the immobility of the jaw remaining unchanged, it became evident that the principle trouble was located on the right side. On account of the duration of the operation, it was decided to postpone the exsection of

the right temporo-maxillary joint. The wound healed promptly. Twenty-six days later, a horizontal incision of $2^1/_2$ inches was carried from the external meatus of the right ear forward along the zygomatic arch. The temporal vessels being doubly tied were severed; and, the region of the joint being exposed, it was found that a solid and rather massive and bony union of the head and coronoid process with the temporal bone had formed, this mass exceeding the normal width of the bone by about half an inch. A wedge of very hard ivory-like bone being removed by the chisel, the jaws could at once be separated freely, the distance between the incisors being 4 cm. This wound was also healed twelve days after, and the jaws could be separated by the patient herself to a distance of 3 cm. Chewing was practiced without difficulty. and the function is excellent to this day. Regarding the causation, the presence of an inflammatory process is indubitable as an important element, probably in the course of a typhoid fever or acute inflammatory rheumatism. Whether the hemiatrophy was due to the presence of the ankylosis is very doubtful, but it seems rational to assume that the atrophy of the temporo-maxillary joint of the left side was caused by the absence of the physiological stimulus of motion in the joint. The operation is rational and safe, and has yielded excellent result to other observers abroad as well as at home. The horizontal incision as devised by Bottom and Kōnig has been found to be the better one, although ligature of the temporal artery cannot always be obviated.

F. LANGE, M. D. (New York) had operated upon a girl, æt. 8, with ankylosis of the jaw after scarlet fever and diphtheria with a consequent otorrhœa and later, measles. At times, the teeth could be more easily separated, when hearing also seemed to be improved. The lower jaw was abnormally small and the left half of the bone seemed shorter than the right, on which side the muscles seemed the more active. From this, thinking the left jaw was the one affected, the joint was exposed by the horizontal incision and not a trace of the articulation could be seen, everything seeming to be changed into one bony mass which had to be chiseled, strictly subperiosteally, away piece by piece. At the end of ten days cicatrization was complete, and the

jaw could be opened about a centimetre, which increased after about six weeks to about $1^1/_4$ inches.

In the case of a child, æt. 6, during birth the blade of the forceps had caused, by pressure, gangrene of the soft parts above the articulation with consequent complete ankylosis. The jaw was less developed than normal. Both joints were excised and also the left coronoid process, since it interfered with movement by striking against the zygoma. The result was good, but the patient died three years later from tuberculosis.—*N. Y. Surg. Society*, Oct. 25, 1886.

JAMES E. PILCHER (U. S. Army).

II. Abscess of Brain Following Compound Fracture of Skull. Drainage. Recovery. DR. W. O. MAHER (Australia). The patient in this most interesting case was a girl, æt. $4^1/_2$, who had sustained a severe compound fracture of the frontal bone on the right side. The removal of some necrosed portions of bone led subsequently to slight hernia cerebri. A sinus persisted, but the child seemed well in other respects until about five months after the accident, when left-sided convulsions (chiefly of the muscles of face and arm) came on, and an alarming condition rapidly developed. The sinus was opened up and a director was passed for a distance of one inch into the right frontal lobe downwards and backwards. A free flow of fœtid pus occurred, and after the cavity had been washed out with carbolic solution (1 in 40), a drainage-tube was inserted. The latter was removed at the end of a fortnight. Left hemiplegia followed the operation, but it passed off some twenty-four hours subsequently. Recovery was rapid and complete.

Dr. Gowers and Mr. Barker (*British Medical Journal*, December 11, 1886) have lately recorded a case of successful drainage of an abscess in the tempero-sphenoidal lobe following suppurative otitis, which appears to be the first on record. Mr. Hulke, however, in 1879 trephined for cerebral abscess (after an injury), and has also recorded in the *Lancet* of 1886 three cases similar to Dr. Gowers's, in which, however, a fatal issue followed the operation in each.

Dr. Maher's case is reported in the *Australian Medical Gazette*, Dec., 1885.

J. HUTCHINSON, Jr. (London).

II. On the Origin of Ranula From the Bochdalek Gland-tubes of the Root of the Tongue. By Prof. E. NEVMANN (Königsberg). Some years since N. reported a case where the lining of a ranula was covered by ciliated epithelium. The ciliated cells were long and rested on a layer of small round cells. Recently von Recklinghausen has published a very similar case. N. is now able to add a third case, though from a poor preparation.

Recklinghausen concluded that such cysts develop from the Blandin-Nuhn gland under the tip of the tongue, though this gland does not normally present ciliated epithelium. Newmann argues at length against this view and in favor of his own, that they originate from the only oral structure bearing ciliated cells, viz., Bochdalek's gland.—*Arch. f. klin. Chirg*, 1886, Bd. 33, Hft. iii.

IV. On the Causation of Fractures of the Larynx.—By Prof. E. von HOFMANN (Vienna). After relating and discussing several cases, the following conclusions are given:

1. Fractures of the larynx, particularly of the large horns of the thyroid cartilage and the bridge of the cricoid may, where these structures no longer possess their youthful elacticity, arise from strangulation, throttling with the hand and various other kinds of direct force.

2. Indirect force also, involving compression of or strain on the larynx, may occasion such fractures.

3. Indirect fractures may arise further, from cutting through the front of the neck if the instrument be too dull or a calcified larynx is met with—or from falling from a height, especially when striking on the head.—*Wien. Med. Woch.*, 1886, Nos. 44 and 45.

V. Tracheotomy in Diphtheria.—SOCIN and KESER report 12 cases (10 of crico-tracheotomy and 2 of superior tracheotomy), with 7 recoveries and 5 deaths. The patients' ages ranged from $2^1/_2$ to 6 years, the youngest recovering. Salicylic spray was regularly used in the after-treatment.—*Jhrsbrecht d. Spital zu Basel* f. 1885.

VI. Fibroma of Vocal Cord. SOCIN AND KESER.—The patient was a woman, æt. 44. Increasing horseness for one and a half

years, and an expectorating cough for two weeks were the only symptoms. Laryngotomy. Tamponade of trachea. Excision by scissors of a small pea-sized tumor from the front third of the left vocal cord. Seried suture. Cure with normal voice.—*Baseler Spital Berecht. f.* 1885.

ABDOMEN.

I. Gastrostomy with Double Stricture of the Œsophagus. By Dr. B. SCHLEGTENDAL (Hannover). The patient was a woman, æt. 24, who four years previously had suffered from severe diphtheria of the throat. Since that time gradually increased difficulty in swallowing. She claimed not to have been able to swallow anything the last week; everything stuck in the throat, and was immediately gagged up. Fluids returned so quickly and completely that they could not have passed down any distance. The finest sound even did not go beyond the aditus laryngis. The obstruction was evidently high up. She was excessively emaciated; no other cause than inanition. Nutrient enema for two days made no objective impression on her condition.

The operation was difficult; stomach stitched to the abdominal opening; morphine injected. That afternoon and during the remainder of life she vomited up an abundant quantity of fœtid, dirty, gray-brown fluid. Rectal alimentation continued. Her failing condition necessitated opening into the stomach a day after the first operation. This viscus was filled with thick fluid, gall-green material in contrast to the vomit. The stomach was washed out, when strong bouillon was well tolerated. A few hours later her condition grew worse, and despite further stimulating, death ensued 45 hours after the first operation.

The autopsy showed that union had taken place between the wound edges of stomach and abdomen. No other sign of peritonitis than slight fluid in abdomen. The fauces narrowed just back of the epiglottis to a funnel with a closed bottom. No passage from above could be found through the cicatricial stricture, though from below a fair sized sound could be passed up through. Below this the œsophagus widened into a broad fusiform dilatation. This still contained